Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005086	A. BUILDING: _____ B. WING _____	03/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJOR HOSPITAL	150 W WASHINGTON ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Date of survey: 3-7-13 Facility number: 005086 Complaint number: IN00119978 Unsubstantiated: lack of sufficient evidence Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Major Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services and 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules. QA: claughlin 03/14/13	S 000		